PRINTED: 06/22/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN333AGC** 05/06/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2305 IVES CT PARK PLACE RENO, NV 89503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 5/6/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 60 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was 36. Fifteen resident files were reviewed and 11 employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified: Y 105 Y 105 449.200(1)(f) Personnel File - Background Check SS=D NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This Regulation is not met as evidenced by: Based on record review and interview on 5/6/09, the facility failed to ensure 1 of 11 employees met background check requirements (Employee #10).

This was a repeat deficiency from the 5/15/08

449.185, inclusive.

PRINTED: 06/22/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN333AGC** 05/06/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2305 IVES CT** PARK PLACE **RENO, NV 89503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 105 Continued From page 1 Y 105 annual State Licensure survey. Severity: 2 Scope: 1 Y 255 449.217(6)(a)(b) Permits - Comply with NAC 446 Y 255 SS=F NAC 449.217 6. A residential facility with more than 10 residents must: (a) Comply with the standards prescribed in chapter 446 of NAC. (b) Obtain the necessary permits from the Bureau of Health Protection Services of the Division. This Regulation is not met as evidenced by: Based on record review, interview and observation on 5/6/09, the facility failed to comply with the standards prescribed in chapter 446 of NAC. The deficiencies are as follows:

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Main kitchen

Slight debris was found on the slicer surfaces. Raw eggs were stored adjacent and above potatoes in the walk-in refrigerator.

The can opener blade was scarred, allowing a

risk of metal fragments entering food.

Debris and spills were noted in the following non-food contact areas: under and nearby the griddle, interior surfaces of the juice dispenser,

and floors behind the stove.

PRINTED: 06/22/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN333AGC 05/06/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2305 IVES CT** PARK PLACE **RENO, NV 89503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 255 Y 255 Continued From page 2 Yellow and Grey houses The cabinetry of the kitchenettes was found worn and potentially able to absorb spills. White house The microwave was domestic grade and does not meet the NRS/NAC 446 requirement of commercial equipment certified to NSF Standards. The microwave was significantly soiled on the inner surfaces of the door and between door panels making it difficult to clean. Vacant Blue house Domestic refrigerators, microwaves, toasters, dishwashers and a coffee pot do not meet the requirement of commercial equipment certified to NSF Standards and cannot remain if and when residents re-occupy the blue house. White, Yellow, Brown and Grey houses Domestic toasters do not meet the requirement of commercial equipment certified to NSF Standards. Severity: 2 Scope: 3 Y 274 449.2175(5) Service of Food - Substitutions Y 274 SS=C NAC 449.2175 5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a conspicuous place during the service of the meal.

PRINTED: 06/22/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN333AGC** 05/06/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2305 IVES CT PARK PLACE RENO, NV 89503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 274 Continued From page 3 Y 274 This Regulation is not met as evidenced by: Based on record review, interview and observation on 5/6/09, the facility failed to comply with NAC 449.2175, which states that any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. It was determined that at least 2 of the last 3 months of meal substitution records were located off the

Y 883

Severity: 1 Scope: 3

Y 883 | 449.2742(7) Medication / Resident Refusal SS=D

premises at an employee's home, as acknowledged by the Administrator.

NAC 449.2742

7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.

This Regulation is not met as evidenced by: Based on record review and interview on 5/6/09, the facility failed to notify the physician of missed doses of medication for 1 of 15 residents (Resident #4).

Severity: 2 Scope: 1

Y 908 | 449.2746(2)(a)-(f) PRN Medication Record SS=A

NAC 449.2746

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Y 908

PRINTED: 06/22/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN333AGC** 05/06/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2305 IVES CT** PARK PLACE **RENO, NV 89503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 908 Continued From page 4 Y 908 2. A caregiver who administers medication to a resident as needed shall record the following information concerning the administration of the medication: (a) The reason for the administration. (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication: (e) The initials of the caregiver; and (f) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident 's physician. This Regulation is not met as evidenced by: Based on record review on 5/6/09, the facility did not ensure the medication record was complete for 1 of 15 residents receiving as needed (PRN) medications (Resident #13). Severity: 1 Scope: 1 Y 920 Y 920 449.2748(1) Medication Storage SS=D NAC 449.2748 1. Medication, including, without limitation, any

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

over-the-counter medication, stored at a residential

facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a

PRINTED: 06/22/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN333AGC** 05/06/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2305 IVES CT** PARK PLACE **RENO, NV 89503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 920 Continued From page 5 Y 920 resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. This Regulation is not met as evidenced by: Based on observation on 5/6/09, the facility failed to ensure that medications to be self administered were stored in a locked container unaccessible to other residents for 1 of 15 residents (Resident #10). Severity: 2 Scope: 1 Y 936 449.2749(1)(e) Resident file Y 936 SS=A NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical

information and any other information related to the resident, including without limitation:

(e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations

adopted pursuant thereto.

PRINTED: 06/22/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN333AGC** 05/06/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2305 IVES CT** PARK PLACE **RENO, NV 89503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 936 Continued From page 6 Y 936 This Regulation is not met as evidenced by: Based on record review and interview on 5/6/09, the facility failed to have adequate evidence that 1 of 15 residents tested positive for tuberculosis (Resident #8). This was a repeat deficiency from the 5/15/09 State Licensure survey. Severity: 1 Scope: 1